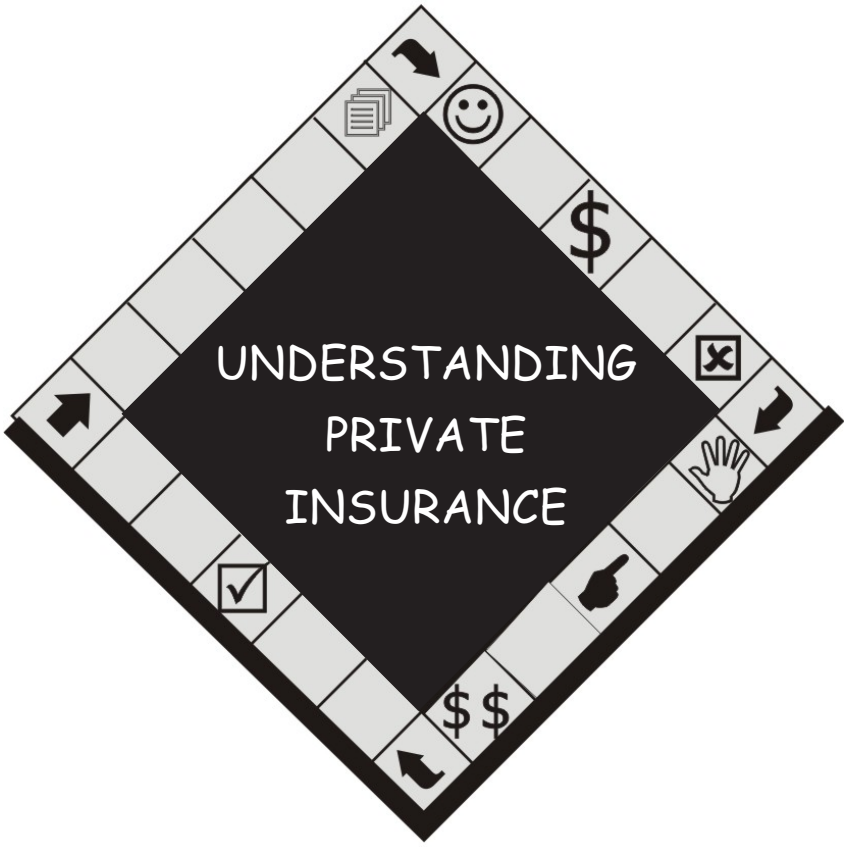
# A Handbook for Families
# Caring for a Child with Mental Health Needs

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Maryland Coalition of Families
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# Maryland Coalition of Families for Children's Mental Health

Our Coalition is a grassroots coalition of family and advocacy organizations dedicated to:

- Improving services for children with mental health needs and their families, and
- Building a network of information and support for families across Maryland.

The Coalition represents families across the state of Maryland who are caring for a child with mental health needs. Many of the children have been in psychiatric hospitals, residential treatment centers, juvenile justice facilities or special education programs.

Each family struggles to find appropriate services for their child and many families face staggering costs for treatment and other special services their child may need.

Even with the challenges of raising a child with serious mental health needs, families have many strengths and want to be full partners with professionals in planning their child's care.

## We Believe

- Children with mental health needs have potential and require specialized services to achieve their full potential.
- Families are the constant in a child's life and are equal partners in planning, implementation and evaluation of services for their child.
- Services should be provided for children and families from a strength-based approach and consider the whole child and entire family.
- Communities should develop a coordinated system of care that is available to all children with mental health needs and their families.

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Maryland Coalition of Families for Children's Mental Health

# Introduction

This guide has been written for families with private health insurance who have children with mental health needs. Our goal is to help parents better understand their child's mental health insurance coverage, limitations and options for appealing decisions. It may be helpful to have a copy of your child's health insurance policy on hand as you read through the guide.

Health insurance is a complex issue. It is important to remember that coverage and protections depend upon your specific policy and situation. Do not assume that another person who has the same insurance company as you do has insurance that is identical to yours. Read your policy carefully and check with your insurance carrier or Benefits Coordinator where you work to find out the particular benefits and procedures for your plan.

## Tips for Navigating Your Insurance

- Read your insurance policy.
- Contact your Benefits Coordinator if you have questions about your benefits or procedures for authorization.
- Keep a record of all contacts with your insurance company including:
    a. Letters or papers you may have received.
    b. Dates and names of people you speak with on the telephone at your insurance company.
- Save your records – for years! You never know when you will need them.
- Always put it in writing! If you have a request or a disagreement with your insurance company write a letter and keep a copy for your records.

Read on ……..

# Understanding Your Health Insurance Plan

## ? What do we mean by private health insurance?

If you or your employer provide coverage for your child under a group or individual policy where premiums are paid, you are considered to be privately insured.

## ? What basic information do I need to know to get answers about my health insurance?

**Policy and Group # where applicable**

**Type of Plan** -The type of plan often depends on who sponsors or maintains the plan.

*What type do you have?*

- Group Health Plans are sponsored by an employer or a union
  a. Small group= two to fifty members
  b. Non-small group= Fifty-one or more members

  Maryland state law specifies minimum mental health benefits based on whether the policy is written for a small group or non-small group.

- Self-Insured Group Health Plans are established by employers who set aside funds to pay their employees' health claims. Because employers often hire insurance companies to run these plans, they may appear to be fully insured plans. In your benefits information, employers must disclose whether an insurer is responsible for funding, or for only administering the plan. If the insurer is only administering the plan, it is self-funded.

- Individual Health Insurance Plans are sold to individuals other than through employers or unions.

- Federal Programs such as Federal Health Benefit Program

- Tricare (formerly Champus) Military Health Programs

**Type of Policy** - Insurance carriers have many different types of policies that they offer customers. The basic types of policies are listed below:

***Fee for Service*** - This is sometimes called Indemnity Health Insurance. With this type of plan, you can use any medical provider and change doctors at any time.

***Managed Care*** - Simply put, this means that someone is reviewing and monitoring the need for and use of services. There are three main types of managed care:

1. *Health Maintenance Organization (HMOs)* – HMOs are the oldest form of managed care and offer members comprehensive care for the insured either directly in its own group practice or through doctors and other health care professionals under contract in private offices. If you belong to an HMO, the plan generally covers the cost of care by doctors in that HMO. If you go to doctors outside the HMO, you will usually pay the bill.

2. *Preferred Provider Organizations (PPO)* – PPOs have specific arrangements with doctors, hospitals and other providers of care who have agreed to accept lower fees from the insurer for their services. Unlike an HMO, it is possible to use doctors who are not part of the plan and still receive some coverage.

*3. Point of Service Plans (POS)* – POS medical plans are a combination of PPO and an HMO. Point of Service uses a primary care physician to make referrals to other providers in the plan. If your primary care physician refers you to someone outside of the network, the insurer will pick up most of the cost. If you refer yourself outside of the network, you may be responsible for a higher percentage or the full cost of the service.

## ? What portion of the bill for services is my responsibility?

As mentioned above, using in-network or out-of-network providers will influence the portion of the bill you pay. Other factors that affect your portion of the bill include:

1. *Deductible* - The dollar amount that you are responsible for before the insurance company will pay for all or part of the remaining covered services. Covered services are medically necessary services permitted by the policy. Generally, there is a deductible for each family member and a maximum family deductible.

2.*Copayment* - The dollar amount that you must pay for each provider visit.

3. Allowed *Charges* - Most insurers have a maximum dollar amount that they will allow for each service. Therefore, if the provider bills at a higher rate, the insurer will reduce the billed charges to the allowed dollar amount and then apply the deductible and co-payment as your share.

4. Out-of-Pocket *limit* - Check with your insurer to determine the maximum amount that your family will have to pay for services in any given calendar year. Note any restrictions.

**Insurance policies vary widely in their coverage, requirements and conditions. Also, individuals and their medical conditions vary. Therefore, throughout this guide, we will refer you to your health insurer or your employer's Benefits Administrator to get specific answers about your policy.**

# Understanding Mental Health Coverage in Your Plan

## ? Did your child have a pre-existing condition present before the issuance of your current insurance policy?

If you child's mental health condition was present before the first day of coverage of your insurance policy, it is possible that your insurer will consider it to be a **pre-existing condition,** thereby not covering it for a period of time. The exclusion period begins on your enrollment date and generally lasts no longer than twelve months. If the policy is part of a "small group," state law prohibits pre-existing condition exclusions. If the policy is part of a "non-small group" plan, the provisions of the federal law known as the Health Insurance Portability and Accountability Act (HIPAA) apply. Refer to the Page 15 of this Handbook for additional information about HIPAA.

## ? Does my insurance plan subcontract mental health coverage to a behavioral health insurer?

Many insurance companies subcontract mental health coverage to Managed Behavioral Health Care Organizations (MBHOs) that specialize in managing mental health services. It is important to know if your health plan has contracted with an MBHO as these organizations have their own network of providers and procedures. For example, there may be a different process to obtain a referral for mental health services than for medical services or there may be a different co-pay for mental health services. Unless there is a problem, many families do not know that a separate company handles their mental health coverage.

## ? How can I find out more about my Managed Behavioral Health Care Organization?

The Maryland Health Care Commission publishes an annual report, "Comparing the Quality of Maryland HMOs: A Guide for Consumers". The Guide also contains information about Managed Behavioral Health Organizations and indicates which health plans subcontract to MBHOs and which MBHOs are accredited. You can download a copy of the guide from the Commission's website at www.mhcc.state.md.us or call 1.877.261.8807 toll free.

## ? Is there a "preferred list of providers" or "network" that my child must see? What happens if I want my child to see someone outside of the network?

Preferred providers are groups of doctors, social workers or psychologists that your insurer has agreed to pay. Your plan may have a co-payment and/or deductible and there is likely a maximum "allowable charge" for each service. If you choose to see doctors outside of this list (out-of-network caregivers), your insurer may not pay for the services or may pay a lower percentage of the provider's bill. However, you will still be responsible for the bill. Ask your insurance carrier if there are any "in-network" child therapists or psychiatrists in your area or whether they can approve "out-of-network" providers if you cannot find an appropriate children's mental health specialist.

Similarly, insurance companies may have contracts with specific hospitals that are "in-network." You may be required to use one of these hospitals in order for insurance to pay for the service (at the "allowed benefit" rate minus any deductible). If you choose an "out-of-network" hospital, your insurer may not pay for services or may pay a lower percentage of the bill. The remainder becomes your responsibility unless you request and get approval for an exception based on your child's unique circumstances.

## ? What is a treatment plan?

Maryland has a uniform treatment plan form that mental health providers must complete and submit to insurance companies. The treatment plan asks for information about:

- ✓ Previous treatment in the past 2 years: *Counseling, hospitalization, substance abuse, or residential treatment*
- ✓ Current diagnosis and assessment: *risk to self or others, ability to function at home, school and with friends*
- ✓ Proposed treatment: *individual, group, family therapy, medication, other*
- ✓ Symptoms that have been evident in the past 2 weeks: *behavior, reasoning, mood, anxiety, substance abuse, or physical symptoms such as changes insleep patterns, eating*

Treatment plans are used to determine if the services to be provided are "medically necessary". Sometimes a treatment plan is required after the child's initial visit with the provider. In some cases, a few appointments (referred to as an "unmanaged corridor" of visits) are permitted before a treatment plan is developed so that the provider can see the child over a period of time before determining the plan of action.

After the insurer reviews the treatment plan, a specific number of units/visits is authorized. You and the provider should receive copies of this authorization. If the number of units/visits is exceeded without another authorization, you may be responsible for the bill.

### ? What is utilization review?

Utilization review (UR) refers to the process that managed care companies use to monitor the appropriateness and cost of care. For example, the number of visits to your child's psychiatrist is reviewed each time a treatment plan is submitted.

### ? What are the criteria used by insurers to approve/disapprove services?

In order for your child's treatment to be approved, an insurer evaluates whether the services to be provided are ***medically necessary and appropriate for the child's condition.*** Three major criteria are used to determine "medical necessity":

1. Services must be ***essential*** for the treatment of the condition – no more or no less than what the patient needs. In other words, insurers do not want to authorize a more restrictive and costly service than the patient requires.

2. Treatment must be ***reasonably expected to improve the child's condition or level of functioning*** and in keeping with ***national standards*** of professional mental health practice.

3. Service must be provided at the most ***cost effective level of care*** and be a ***covered service*** under the insurance plan

**Be sure to check with your insurer to determine if prior authorization and/or a referral from your Primary Care Physician are needed before accessing services. Failure to obtain pre-authorization is a major reason why insurers deny claims.**

## Knowing What Services Are Covered

? **What kind of mental health services are covered for my child?**

In addition to outpatient visits and acute hospitalization, there are other mental health services that your child and family may require. For example, once an acute hospital stay is completed, some children are referred to a ***day or partial hospitalization program***. Generally, insurance companies recognize the value of this alternative as part of a transitional plan. Ask your insurance carrier.

A ***residential treatment center (RTC)*** involves a longer-term stay than acute hospitalization and is for chronic situations. Many insurers do not normally pay for this type of program. However, exceptions are sometimes made. If your child needs residential treatment, it is important to contact your insurance company as soon as possible because any approval is likely to be a lengthy process.

Your insurance company may suggest ***therapeutic foster care*** as an alternative to residential treatment. Therapeutic foster care is where a family that has received special training in working with children with mental health problems takes the child into their home for a period of time and is reimbursed on a contractual basis by the insurer.

***Intensive care management*** is a service that you may wish to discuss with your insurer if your child's situation is serious and complex. If approved for intensive care management, you are assigned a case manager who assists you in coordinating your child's care. Benefits that are not normally covered may be provided as needed under intensive care management.

***Experimental procedures/therapies*** are generally not covered by insurance unless they are part of a regular visit that has been authorized. Again, check with your insurer.

Your family may need to find ***respite care*** for your child regularly or intermittently so that you have some time to regroup. It is not uncommon for families to feel exhausted and unable to deal with the child's mental health problems all the time. Check with your insurer to see if they will pay for the service.

If your child requires ***hospitalization***, your insurer may require ***family therapy*** as a condition for payment of the bill. Family therapy is viewed as a part of your child's therapeutic program. If you child is admitted to the hospital as an ***emergency admission***, be certain that your insurer has been contacted by the hospital within the first working day to avoid payment problems.

### ? What happens if my child needs to be hospitalized for psychiatric treatment?

Hospitalization often occurs in an emergency situation. During a crisis, your foremost concern is your child and it is difficult to think about matters such as insurance. Understanding your policy is critical at this time in order to ensure that your child receives the best treatment possible.

Your child may go to an emergency room first for an evaluation. If the physician determines that your child needs inpatient hospitalization, the hospital will contact your insurance company and request authorization for inpatient treatment.

If the insurance company approves inpatient hospitalization, they may also specify the hospital to which your child is admitted. This could necessitate transferring your child from the emergency room at one hospital to another hospital where your child is admitted for treatment.

At first, insurance companies authorize 2-3 days in the hospital. The hospital must then contact your insurance company and request authorization for additional days of treatment. If your child is denied additional days and you believe your child needs to stay in the hospital, you will need to contact your insurance company and file an ***emergency appeal***. Urgent requests for an extension of benefits must be decided within 24 hours. Refer to page 11 of this handbook to read more about how and where to file an ***appeal or a grievance***. You may have to be patient and pursue several levels of appeal.

### ? How do insurers address substance abuse issues?

Generally, insurance companies policies do not distinguish psychiatric problems from alcohol and drug abuse issues. However, when you contact your insurer, you may be directed to a different customer service representative who specializes in substance abuse issues.

### ? Are court ordered mental health services covered under my insurance?

Not necessarily. Insurance companies are not bound by court orders. The services must meet the medical necessity criteria and be a service covered by your plan. If the Court orders treatment from a particular provider and your insurer does not normally cover the provider, you may be responsible for the bill. In-network and out-of-network standards still apply even if the treatment is court ordered.

## ? If my child is in special education, are mental health services covered under my insurance plan?

If your child is in special education, the federal special education law, IDEA, requires that your child receive the services he/she needs to meet their unique needs. If your child's Individualized Education Plan (IEP) includes mental health services such as individual counseling, group counseling, family counseling or psychiatric consultation, the local school system is required to provide the service(s) at no cost to the family.

Under IDEA, the school system may ask your permission to access your private insurance for mental health services provided in your child's school. This is your choice. You may decide to allow the school system to file claims with your private insurance or you may decline to give permission to access your private insurance. If you decline, the school system is still obligated to provide mental health services listed on your child's IEP at no cost to your family.

## ? What school mental health services does my insurance cover if my child is not in special education?

Many schools are developing "school-based" mental health services where therapists provide individual or group counseling in the school. These services are not entitlements as they would be for children in special education. You may be asked to pay for these services. Generally, private insurance would only cover these services if the therapist working for the school were also a part of your insurance company's provider network.

## ? What about psychological testing?

Your insurer may cover psychological testing if your child is exhibiting emotional, behavioral or psychological issues. Testing for learning disabilities may *not* be covered. Check with your insurer if you believe that psychological testing is needed.

You may also request an evaluation from your child's school. Put your request in writing to the principal of the school. Be sure to keep a copy of your letter and follow-up with a phone call.

# Transitions

## ? What happens when my child "ages out" of my family insurance policy?

As your child approaches adulthood, it is important to look into options for continuing health insurance. It is imperative to plan for your child's coverage since policies have cut-off ages whereby your child may no longer be eligible under the family policy. Generally, 19 is the cut-off age for eligibility unless:

- The child attends a college or university carrying at least 12 credits a semester; or,
- The child attends graduate school carrying at least 9 credits a semester.

If your child remains a full-time student at a college, university or graduate school, there is often a maximum cut-off age of 23-25 years, depending on the policy.

The other exception to "aging out" of the family's policy can occur when the child, having reached 19 years of age, is mentally or physically incapacitated. Maryland state law requires insurers to continue coverage if the child is proven to be "incapable of self-support".

For children who have reached age 19 and do not fall into any of the categories above, the purchase of health insurance may be an alternative. Provisions of the COBRA and HIPAA federal laws may apply. Refer to Page 14 of this Handbook for additional information about these federal laws. If at all possible, do not allow any time to elapse between the expiration of your child's coverage under the family policy and purchase of continuing or new coverage.

When your child reaches 18, they may become eligible for Supplemental Security Income (SSI) if they meet the following criteria:

- their income and assets meet Social Security guidelines, and
- their disability interferes with employability.

If your child qualifies for SSI, they will also qualify for Medicaid. Refer to the Appendix in this Handbook for additional information on ways to access Medicaid for your child.

# How to File an Appeal or Grievance

## ? What happens if I disagree with my insurer?

If your doctor has determined that certain medical treatment is needed but your insurer denies payment for treatment, you have the right to file a grievance. This is known as an **internal appeal**. Every insurance company is required by law to have an appeal process. Insurance companies are required to provide you with a copy of the insurer's appeal process and denial of services in writing. The denial letter should provide the insurance company's reasons for not paying for the services. If you do not receive a written denial letter or a copy of the insurer's appeals process, contact your insurer and request this information. Refer to page 13 for hints on making phone calls or writing letters to appeal a decision. Insurers often have several levels of internal appeals. If you are dissatisfied, don't give up — especially since denials that are upheld at the first level can be reversed at a different level of appeal.

If you need help filing an appeal the Health Education and Advocacy Unit of the Office of Maryland's Attorney General can assist you. You can download complaint forms from their web site at www.oag.state.md.us or call 1.877.261.8807 toll free. Typical complaints include billing and reimbursement problems, medical records access, medical equipment sales, utilization review and management concerns. The Unit uses mediation to try to bring about a cooperative resolution to the problem.

If your child has compelling circumstances (an emergency), it may be possible to bypass the internal grievance process and file an emergency appeal. In this expedited external review process, a decision by the Maryland Insurance Administration must be provided in 24 hours. Contact the Appeals and Grievance Unit of the Maryland Insurance Administration at 1.800.492.6116 toll-free for information.

## ? What can the Maryland Insurance Administration do to help?

The Maryland Insurance Administration (MIA) investigates complaints and can issue orders and penalties to insurance companies who issue policies in Maryland, and therefore subject to the jurisdiction of the State's insurance laws. If a plan is self-funded or insured, a federally issued plan or a policy issued in another state, Maryland law does not apply and therefore the Maryland Insurance Administration does not have jurisdiction.

In order to file an appeal with the MIA, you must have exhausted your insurance carrier's internal appeal process, except in compelling circumstances. The Maryland Insurance Administration uses medical experts on staff and Independent Review Organizations to work on appeal cases. MIA has 30 working days to investigate and finalize a decision. In cases where services have already been provided, MIA has 45 working days to finalize the case.

The Maryland Insurance Administration (MIA) website describes the Maryland's Appeals and Grievances Law. Complaint forms can be downloaded from their website at www.mdinsurance.state.md.us or call 1.800.492.6116.

## ? What can I do if my plan is not issued in Maryland?

The type of plan you have will determine who to contact in order to file a complaint. The chart below may help you determine the most appropriate place to start.

### Contacts for Filing a Complaint

| Type of Plan | Contact | Where |
|---|---|---|
| Group Health Plans issues in Maryland | Maryland Insurance Administration | 1.800.492.6116 www.mdinsurance.state.md.us |
| Group Health Plans issued in other states | Insurance regulator for the state in which the plan is issued | Contact National Association of Insurance Commissioners to obtain the insurance regulator for the state that issues your health plan. 1.816.842.3600www.naic.org |
| Federal | U.S. Office of Personnel | Retirement Benefit Branch 1.202.606.0500 www.opm.gov/insure/health |
| Self Insured/Self Funded Plans | U.S. Department of Labor | Pension and Welfare Benefits Administration, Div. of Technical Assistance 1.202.219.8776, ext. 43039 www.dol/gov/pwba/ |
| Tricare Military Health | Managed Care Support Contractor for Northeast Region | Sierra Military Health Services 1.888.999.5195 www.sierramilitary.com |
| Individual Health Plans | Maryland Insurance Administration | 1.800.492.6116 www.mdinsurance.state.md.us |

It is important to note that some of these agencies do not have regulatory power. That means they do not have the authority to reverse a decision made by an insurance company. Nevertheless, you should proceed to file a grievance. While this may not help your child's immediate situation, registering your complaint may lead to changes in laws that may help other children and families in the future.

# Hints for Phone Calls and Letters

If you are the parent of a child with mental health/substance abuse issues and you are navigating the private health insurance system, you are undoubtedly experiencing some stressful times. Here are some helpful hints for a phone call and a letter to your insurance company.

***Sample Phone Call*** if you disagree with a decision

1. Call your Health Plan's customer service number and explain the situation.
2. Tell the plan representative that you disagree and ask what the plan will do to help resolve the issue. Clearly state what you want to happen.
3. Ask how long it will take them to get information or answers to you.
4. Be sure to write down what was said, the date, the name of the person you spoke with and what you talked about. If you do not understand what the customer service representative said, ask to speak with a supervisor.

***Hints for Writing a Letter*** about denial of services

1. Contact the insurance plan to find out how the letter should be addressed.
2. Be sure to show your child's name and chart or account number within the plan, your address and phone number.
3. Begin your letter with a brief statement of who you are and why you are writing.
4. If you are requesting a written explanation of the reason for denial, state that you have reviewed your contract and cannot find a valid reason for the denial in your policy. **Ask for specifics**, not just a response that states "not a covered benefit" or "not medically necessary."
5. If you are challenging a denial, state your understanding of the denial and explain why you feel the services are necessary and/or should not be denied. Use any supporting professional opinions.
6. Include dates and names of people in the managed care plan you have already talked with.
7. Ask for a response (a letter or phone call) within a reasonable time. State a date that you want to hear back from the plan. Don't wait too long. Your plan may have very limited time periods to file an appeal.
8. Have someone proofread your letter.
9. Keep a copy for your personal records.
10. Send a copy to: Consumer Protection Division
    Office of the Attorney General
    Health Education and Advocacy Unit
    200 St. Paul Place, 16th Floor
    Baltimore MD 21202

# Important State and Federal Laws

In recent years, several key federal and state laws have been passed that may have an impact on your child's mental health coverage.

## Mental Health Parity

In 1994, Maryland enacted **parity laws** prohibiting insurers from discriminating against mental health coverage compared to health coverage for physical illness. Before parity laws, many insurers set limits on mental health coverage that were out- of-line with other health conditions. Now, the mental health benefit requirements differ depending on whether your insurance coverage is part of a small employer contract or large group and individual contracts.

## COBRA and Maryland Continuous Coverage

If you leave an employers' group health plan due to reasons such as voluntary or involuntary job loss, reduction in hours worked, transition between jobs, death, divorce, and other life events, you may be entitled to continued coverage under your former group health insurance. The 1985 federal called COBRA (Consolidated Omnibus Budget Reconciliation Act) gives employees and their dependents who leave an employer's group health plan the opportunity to purchase and maintain the same coverage over a period of 18 months. Under certain circumstances, COBRA can be extended to 36 months. For more details, contact your former Benefits Coordinator.

Maryland also has laws requiring insurers, non-profit health service plans and HMO's to offer continuous coverage to individuals who lose group insurance coverage due to:

- voluntary and involuntary loss of employment
- death
- divorce

Contact the Maryland Health Insurance Administration for more information about "continuation coverage." Both COBRA and Maryland's continuation coverage laws require you to pay the insurance premiums yourself. The advantage is that you are able to pay the group rate premium.

## HIPAA

The Health Insurance Portability and Accountability Act of 1996, known as HIPAA offers several protections:

- ✓ Limits the use of pre-existing condition exclusions
- ✓ Prohibits group health from discriminating by denying coverage or charging more for coverage based on your family member's past or present condition
- ✓ Guarantees certain small employers and individuals who lose job-related coverage the right to purchase health insurance
- ✓ Guarantees, in most cases, that employers or individuals who purchase health insurance can renew the coverage regardless of any health conditions of individuals covered under the insurance policy

Information about federal laws is available through the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA). The CMS website, cms.hhs.gov, has an online tool to answer your questions about health insurance coverage and your rights and protections under HIPAA. You can also contact the CMS Regional Office for Maryland, located in Philadelphia PA at 215.861.4140.

## Maryland's Mandated Benefits

Maryland law requires insurers to include certain health benefits in all contracts. The following is a description of mental health benefits that generally are required in health benefit contracts issued in Maryland.

- ❒ Inpatient - Covered the same as inpatient treatment for physical illness - small employer health plans limit to 60 days per year
- ❒ Outpatient - Cover 80% for first 5 visits per year; 65% for next 25 visits per year; and 50% for remaining visits in that year. For small employer health plans, 70% for all visits; 50% out-of-network for PPO, POS, triple option HMO
- ❒ Medication Management - Covered same as office visits for a physical illness
- ❒ Detoxification - Required in small employer health plan only
- ❒ Partial Hospitalization - Benefit may be limited to 60 days per year. In small employer health plan, partial hospitalization days are subject to the inpatient limit but are substituted at the rate of 2 to 1 for inpatient benefits.
- ❒ Residential Crisis Services - Requirement applies effective October 1, 2002; benefit not required in small employer health plan

# Conclusion

One last thought. . .

Information in this Handbook is a *start* to help you find the answers you need. Always refer to your policy, your health insurance company or your employer's Benefits Coordinator to get answers to specific questions.

While it may be frustrating at times, keep in mind that your efforts are for the benefit of your child's mental health. Remember. . .you are not alone. For additional resources, go to our website at www.mdcoalition.org. We wish you and your family the best.

Maryland Coalition of Families for Children's Mental Health

# APPENDIX

# Appendix

In most instances, if you have private insurance your child will not qualify for publicly funded programs. However, eligibility requirements change and your family's circumstances many change so it is important to check out whether your child may qualify. This Appendix contains information about some of the state and federally funded programs.

## Supplemental Security Income (SSI)

Supplemental Security Income is a program operated under Social Security Administration that provides monthly financial assistance for children under 18 whose disability is expected to last more than 12 months or result in death or whose parents' income and resources are limited. When a child with a disability turns 18 they become eligible for SSI depending upon two criteria:

1) Their own income and assets
2) Their ability to work and become self-supporting.

Mental health and behavior problems are considered differently from other types of disabilities. You will need to provide medical documentation of your child's limitations and needs. The process of applying for SSI may be lengthy and you may be told your child is not eligible because they are not disabled. You may request reconsideration or appeal the decision.

The Social Security website, www.ssa.gov, contains information about SSI. You can also contact your local Social Security office by looking under "United States Government" in the blue pages of your telephone directory.

## Pharmacy Assistance

The Maryland Pharmacy Assistance Program (MPAP) is a state program that provides help to residents who are not eligible for participation in the Medicaid Program. It covers certain pharmacy and related supplies for people who are above the income or asset scale for regular Medicaid. There are rigid income guidelines that restrict eligibility. To apply contact your local Health Department or Department of Social Services. Information is available at the Department of Health and Mental Hygiene website, www.dhmh.state.md.us/mma/mpap.

# Maryland Children's Health Program (MCHP)

MCHP is a Medical Assistance program for uninsured pregnant women of any age and children up to age 19 if they have a family income that is at or below:

**For Children**

$23,880 for a family of 2
$30,040 for a family of three
$36,200 for a family of four

Add $6,160 for each additional family member to determine eligibility for larger families.
(*Income eligibility levels as of June 2002.)*

MCHP offers a full benefit package for children and young adults. There are no limits on health services that may be provided as long as they are medically necessary.

Contact your local Health Department or Department of Social Services to apply for the MCHP program.

Mental health services under MCHP are managed by Maryland Health Partners. If your child needs mental health services, contact Maryland Health Partners for additional information. 1.800.888.1965

**Private Insurance and Medical Assistance**

Some children may be covered by private health insurance and also qualify for Medical Assistance. Federal law says that you must first use your private insurance before using Medical Assistance. Always request services from your insurance company first. If you are denied or told that the services are not covered under your policy, ask for the denial in writing and submit the letter to Maryland Health Partners with a request for approval of services.

If services such as outpatient counseling are covered by your insurance policy but you will be charged a co-pay, you will need to ask for prior authorization from both Maryland Health Partners and your insurance company. You will also need to use a provider who is accepted by both Maryland Health Partners and your insurance company.

# Points of Entry into Maryland Medicaid and Medical Care Programs for Children with Special Health Care Needs

### Maryland Children's Health Program (MCHP)

MCHP is a program for uninsured pregnant women of any age and children up to age 19 If they have a family income that is at or below:

***For Children:***

$23,880 for a family of two
$30,040 for a family of three
$36,200 for a family of four

*Add $6160 for each additional family member to determine eligibility for larger families.*

***For Pregnant Women*:***

$29,850 for a family of two
$37,550 for a family of three
$45,250 for a family of four

**numbers include unborn child - Add $7070 per additional family member*

MCHP offers a full benefit package for children and young adults. There are no limits on the health services that may be provided as long as they are medically necessary.

Most children with health care needs who are eligible for MHCP will be enrolled in HealthChoice. HealthChoice offers a choice of several managed care organizations (MCOs) depending on where you live.

Some children with special health care needs may qualify for the Rare and Expensive Case Management program or REM. This program offers intensive case management and services are provided on a fee-for-service basis.

Ask your child's current providers if they are participating in the MCO you are considering or the REM program if applicable.

**For more information call 1-800-456-8900**

### MCHP Premium

MCHP *Premium* is new low cost health insurance coverage for uninsured children under the age of 19. MHCP *Premium* provides access to health insurance coverage for eligible children through their parent's or guardian's employer-sponsored insurance (ESI) or through the Maryland Managed Care Program, *HealthChoice* for a modest monthly premium. Families must have income at or below:

$35,820 - family of two
$45,060 - family of three
$54,300 - family of four

Please note the MHCP guidelines in the first box on the left. Families meeting these income limits are all no-cost HealthChoice eligible. Coverage provided through your employer must meet a standard state benchmark for the benefits your child receives. However, benefit limitations may exist on ESI policies.

**For more information call 1-800-456-8900**

### Supplemental Security Income (SSI)

SSI is a Federal program that provides income and access to Medicaid via Maryland's HealthChoice or REM (Rare and Expensive Case Management) programs to children under age 18 who have a disability, are blind, or have a chronic illness. Adults 18 and over with a disability may also qualify. Eligibility is based on the child's disability and financial need. For individuals under age 18, the family's income is used to determine eligibility. For those 18 and over, only the applicant's income is counted. Children who qualify for the Federal Supplemental Security Income or SSI automatically qualify for Medicaid. Call us for a how-to guide to SSI in Maryland.

**2002 Sample earned monthly income**

| # of other children *without* a disability in the home | One-Parent Household | Two-Parent Household |
|---|---|---|
| 0 | $2305 | $2849 |
| 1 | $2577 | $3321 |
| 2 | $2849 | $3393 |
| 3 | $3121 | $3665 |

Documentation of the child's disability, disease, or chronic illness must be presented with the application along with proof of income and assets.

**For more information call your local Social Security office or the national number at 1-800-772-1213**

***Waiver Programs***

*Waiver programs use the child's income to determine eligibility.*

### Autism Waiver Program

The Autism Waiver Program is administered by the Maryland State Department of Education. The waiver serves children ages 1 through the end of the school semester that the child turns 21, who are diagnosed with autism. As a part of determining eligibility, a child must be diagnosed with Autism Spectrum Disorder, meet an Intermediate Care Facility for the Mentally Retarded Level of Care, not be enrolled in any other waiver program, and have an Individualized Educational Program (IEP) or Individualized Family Service Plan (IFSP) and receive at least 15 hours of special education and related services per week. The services that will be provided under the Autism Waiver are respite care, family training, environmental accessibility adaptations, supported employment, day habilitation, residential habilitation, targeted case management, and health benefits through Medicaid.

**For more information call 410-767-0264 or 410-767-5220**

### Developmentally Disabled Waiver Program

The Home and Community-Based Services Waiver for Mentally Retarded/Developmentally Disabled Individuals, began in February of 1984, to provide services for developmentally disabled individuals, who meet an Intermediate Care Facility for the Mentally Retarded (ICF-MR) level of care, as an alternative to institutionalization in an ICF-MR. Covered services under the waiver include day habilitation, residential option services, respite care, services coordination, environmental modifications, assistive technology, adaptive equipment and health benefits through Medicaid. This waiver program is administered by the Developmental Disabilities Administration of the Maryland Department of health and Mental Hygiene.

**For more information call 410-767-5600**

### Model Waiver Program

The Model Waiver targets individuals with complex medical needs including technology dependent individuals who, before the age of 22, would otherwise be hospitalized and are certified as needing hospital or nursing home level of care. Through the waiver, services are provided to enable medically fragile children to love and be cared for at home rather than in a hospital. Model Waiver services include case management, private duty nursing, shift home health aide assistance, physician participation in the plan of care development, durable medical equipment and supplies and health benefits through Medicaid. Individuals who would like to apply for Model Waiver Services must contact the Coordinating Center for Home and Community Care, Inc., a case management organization.

**For more information call 410-987-1048**

*Information for this fact sheet was gathered from Theresa McIntyre at Baltimore Health Care Access and the Department of Health and Mental Hygiene website.*

# Resources

## Private Insurance

**Consumer Protection Division**
**Office of the Attorney General**
**Health Education and Advocacy Unit**
200 St. Paul Place, 16th Floor
Baltimore, MD 21202
1.877.261.8807
www.oag.state.md.us

**Maryland Health Care Commission**
4201 Patterson Avenue, 5th Floor
Baltimore, Md. 21215
1.877.245.1762
www.mhcc.state.md.us

**Maryland Insurance Administration**
525 St. Paul Place
Baltimore, Md. 21202
1.800.492.6116
www.mdinsurance.state.md.us

## Publicly Funded programs

### STATE

**Maryland Children's Health Program (MCHP)**
1.800.456.8900 or
Contact your local Health Department
or Department of Social Services
www.dhmh.state.md.us/mma/mchp

**Maryland Health Partners**
Administers mental health services for public mental health system
1.800.888.1965
www.mdhp.com

**Maryland Pharmacy Assistance Program**
1.800.492.1974 or
Contact your local Health Department
or Department of Social Services
www.dhmh.state.md.us/mma/mpap

### FEDERAL

**Centers for Medicare and Medicaid Services**
Region III: Philadelphia Regional Office
Ste 216, The Public Ledger Bldg.
150 South Philadelphia Mall West
Philadelphia PA 19106
1.215.861.4140
cms.hhs.gov

**Social Security Administration**
1.800.772.1213 or
Contact your local Social Security office
by looking under "Unites States Government"
in the blue pages of your telephone directory
www.ssa.gov

## Publications

**"Comparing the Quality of Maryland HMOs: A Guide for Consumers"**
Maryland Health Care Commission
1.877.261.8807
www.mhcc.state.md.us

**"Consumer's Guide to Getting and Keeping Health Insurance"**
Georgetown University Institute for Health Care Research and Policy
Guides are online for each state and the District of Columbia.
1.202.687.0880
www.healthinsuranceinfo.net

**"Protecting Your Health Insurance Coverage"**
CMS Publication No. 10199
To order, call toll free 1.800.633.4227.
To download, go to
www.hcfa.gov/medicaid/hipaa.

# References


1st Insured, Everything Insurance, "Individual Medical Health Insurance Information", www.1stinsured.com/individual_medical_insurance.htm.

American Academy of Child and Adolescent Psychiatry, AACAP Facts for Families, #26. "Being Prepared: Understanding Your Mental Health Insurance", www.aacap.org/publications/factsfam/insuranc.htm.

Agency for Healthcare Research and Quality "Choosing and Using a Health Plan", www.ahrq.gov/consumer/hlthpln1.htm.

Center for Medicaid and Medicare (CMS) formerly Health Care Financing Administration (HCFA), *"Protecting Your Health Insurance Coverage",* www.hcfa.gov/medicaid/hipaa/online, September 2000.

NAMI Maryland, "Understanding Maryland's Health Insurance Appeal Law", Winter 2002 newsletter.

National Endowment for Financial Education, "Possibilities: A Financial Resource Book for Parents of Children with Disabilities", 2001.

*Psychiatric News*, "States Turn to External Review, But Few Patients Follow", 4/19/02.

U.S. Department of Health and Human Services, Maternal and Child Health Bureau, "Finding Your Way in Managed care, A Guide for Washington Families of Children with Special Health Care Needs", undated.

Website of the Maryland Insurance Administration - www.mdinsurance.state.md.us

Website of the Maryland Health Care Commission - www.mhcc.state.md.us

Website of NAMI (National Alliance for the Mentally Ill) - www.nami.org/policy/stateparitychart.html

Website of Social Security Administration - www.ssa.gov

Health Care Plan _____

Telephone Number _____

Managed Behavioral Health Care Organization (MBHO) _____

Telephone Number _____

Policy # _____

Annual Deductible _____

# NOTES